MDR Tracking Number: M5-04-0522-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on October 20, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, joint mobilization, myofascial release, manual traction, physical performance testing/muscle testing, therapeutic procedures and range of motion studies were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 04-14-03 to 06-11-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 2nd day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PNR/pnr

NOTICE OF INDEPENDENT REVIEW DETERMINATION
REVISED 12/22/03

MDR Tracking Number: M5-04-0522-01

December 15, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Available information suggests that this patient reports injury to her back while performing work related duty on ___. She appears to present initially to her chiropractor, ___, on or about 12/16/02. Chiropractic notes suggest that no significant past medical history is obtained. The patient is diagnosed with lumbar disc disorder with myelopathy and lumbar nerve root compression. X-rays are found essentially normal. Treatment is prescribed for active and passive therapy at 4x per week for 4 weeks. MRI is obtained 2/10/03 suggesting no disc desiccation or interspace narrowing. No stenosis is present and there is no evidence of nerve root compression. Neurodiagnostic testing obtained 3/20/03 suggests no evidence of lumbar radiculopathy, plexopathy or myelopathy. ___ appears to refer this patient to an associate, ___, on or about 1/27/03 for ongoing passive and active therapy modality applications. Again, no significant past medical history is assessed. The patient continues with multiple passive treatment applications in addition to as many as five units of therapeutic exercise with ___ through 7/30/03. Multiple repeat ROM studies are obtained without clinical correlation provided in treatment notes. There is a designated doctor evaluation performed on 6/12/03 by a ___. Significant past medical history reveals previous unresolved lower back conditions dating back to 1996 and 1997 (there is no mention of these in chiropractic reporting). ___ impressions are that of resolving lumbar strain with left T12 segmental wedging and degenerative L5/S1 annular disc bulge that appear to be of a pre-existing nature. The patient is placed at MMI with a 5% WP impairment rating.

REQUESTED SERVICE (S)

Determine medical necessity for chiropractic services including office visits, joint mobilization, myofascial release, manual traction, physical performance testing/muscle testing, therapeutic procedures and range of motion studies for dates in dispute 4/14/03 through 6/11/03.

DECISION

Deny.

RATIONALE/BASIS FOR DECISION

Six to eight months of passive and active physical therapy treatments appear exceedingly high for lumbar sprain/strain injuries superimposed on pre-existing conditions. Even with co-morbidity of pre-existing conditions, chiropractic documentation does not support working diagnosis or level, frequency and duration of care provided for compensable disorders. Office visits, joint mobilizations, therapeutic modalities, therapeutic procedures and repeat ROM studies are not supported as medically necessary for the dates in dispute 4/14/03 through 6/11/03.

- Essentially negative objective imaging and neurodiagnostic studies
- Unsupported chiropractic working diagnosis
- Failure to evaluate significant past medical history and clinically correlate diagnostic findings with ongoing treatment plan

1. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: findings from the UCLA Low Back Pain Study. J. Manipulative Physiol Ther 2002; 25(1): 10-20
2. Bigos S., et al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
3. Hoving JL, Koes BW, de Vet HCW, van der Windt DAWM, Assendelft WJJ, van Mameren H, et al. Manual therapy, physical therapy or continued care by a general practitioner for patients with low back pain. A randomized, controlled trial. Ann Int Med 2002; 136:713-711.
4. Morton JE. Manipulation in the treatment of acute low back pain. J Man Manip Ther 1999; 7(4): 182-189.
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1992.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.